

Breaking Barriers to Long Acting Reversible Contraception:
Preventing Rapid Repeat Pregnancy in Latina Teens

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Introduction

The Issue of Latina Teen Pregnancy

Although the teen pregnancy rate for Latinas has decreased 44% from 1990-2009, the birth rate for Latina teens was 4.6% in 2012. This rate is more than twice the rate for non-Latina white teens. Most of these births were first births (80%), but more than 17% of births to teens aged 18-19 were second births in 2012. The birth rate to Latina teens was highest in the southeastern United States although the highest numbers of births to Latina teens occurred in California and Texas (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2013). As more Latinos and Latinas are immigrating to the southeastern United States, it is important that clinicians be prepared to meet the physical and educational needs of these patients.

Rapid repeat pregnancy (RRP) puts women and their babies at significant risk. RRP is a pregnancy occurring within 24 months of a previous pregnancy (Baldwin & Edelman, 2013). Negative birth outcomes are more common when there are short intervals between pregnancies. RRP is also most common among women who are poor or from minority groups. For families who are already economically disadvantaged, the outcomes of RRP may cause extra financial strain and emotional stress, especially if the newborn experiences complications (Baldwin & Edelman, 2013). This cycle of poverty, repeat pregnancy, and further financial burden can be devastating to a mother and a family. When a teen becomes a mother, she is significantly less likely to earn her high school diploma. Only 50% of teen mothers graduate from high school by age 22 compared to 90% of women who did not experience teen pregnancy (Eisenberg, McNicholas, & Peipert, 2013). There are a variety of factors that affect a teen mother's ability to care for her child as well as herself, so it is important to help these mothers set themselves up for

success. It is clear that teen pregnancy and RRP in Latinas put a heavy burden on this already vulnerable population, and, therefore, should continue to be addressed.

The Proposed Solution

Contraception is the most effective way to prevent teen pregnancy, specifically RRP. It is crucial that contraception, specifically Long-Acting Reversible Contraception (LARC) begins immediately after an abortion or early in the postpartum period, however teens do not usually begin contraception this early. The American Congress of Obstetricians and Gynecologists (ACOG) recommends that intrauterine devices (IUDs) and implants “should be considered as first-line choices for both nulliparous and parous adolescents,” (Hillard, 2012, p. 40). These forms of LARC are effective at preventing over 99% of pregnancies with continuation rates of 80-90%. On the other hand, methods such as the pill, patch, vaginal rings, and injections are about 90% effective at preventing pregnancy with a continuation rate of about 40-50%. In teens, the effectiveness of these methods is usually lower than 90% because of inconsistent use (Baldwin & Edelman, 2013). Despite lower effectiveness, teens are more likely to use condoms and oral contraception to prevent pregnancy. Due to the typical use and effectiveness of non-LARC methods by teens, adolescents who do not choose LARC methods or do not begin them early enough have 35 times the risk of experiencing RRP compared to adolescents using LARC (Baldwin & Edelman, 2013). This is a significant gap between the most effective and the most common methods chosen by teens to prevent pregnancy, despite recommendations by the ACOG.

The Barriers to Use of LARC for Teens

Despite evidence of the disparity between the most common and the most effective contraceptive methods, slow progress has been made to reduce it. In a poll of 816 physicians and

advanced practice clinicians in 2008, 40% did not offer intrauterine contraception to patients seeking contraception (Russo, Miller, & Gold, 2013). The cost of LARC methods has been one of the main barriers to use. When LARC has been provided free of charge to patients, it has resulted in significantly higher use, and therefore lower birth rates and abortions (Eisenberg et al., 2013). Myths about LARC have persisted as well, deterring patients from choosing these methods. These myths are especially prominent among populations who could receive the greatest benefit from LARC (Russo et al., 2013). Adolescent mothers are less likely to be informed about different types of contraceptives and are more likely to have misconceptions about the risks and adverse effects of each type. Communication and education through counseling between the patient and provider is the third barrier to promoting the most effective contraceptive use and reducing teen pregnancy and RRP. The emphasis of family planning has been the provider giving objective information to the patient without suggesting one method over another. In recent studies, patients have shown a preference for the provider to give advice about methods they recommend rather than delegating the decision entirely to the patient (Dehlendorf, Levy, Kelley, Grumbach & Steinauer, 2013). In this paper, my goal is to address the barriers to providing LARC for adolescent Latina patients who have had one previous pregnancy and to create a tool to facilitate communication between the provider and the patient that can address these barriers. The goal of this study is to improve the lives of Latina teens and their children by giving them the knowledge and resources to make an informed decision about contraception, which can ultimately affect their quality of life and potential for success.

Addressing Barriers to Care

Cutting Cost

The initial cost of both the LARC device and insertion procedure has prohibited many women and adolescents with limited or no contraceptive insurance coverage from using this form of contraception. For IUDs such as Paraguard and Mirena, the cost for the devices is over \$700 and close to \$850, respectively. The sub-dermal hormonal implant, Implanon, is close to \$800. These costs are not including the appointment or the insertion procedure (Eisenberg et al., 2013). When an uninsured woman has a child, however, the cost of the delivery and postpartum care is covered by standard Medicaid or Emergency Medicaid. In total, the cost to the U.S. taxpayers is about \$11 billion dollars every year to pay for about 1 million unintended pregnancies (Peipert, Madden, Allsworth & Secura, 2012). In order to reduce this cost, the Obama administration added an amendment to the Affordable Care Act (ACA) that requires all FDA-approved contraceptives to be covered with no cost to patients with private insurance or Medicaid (Eisenberg et al., 2013). This amendment was supported by the Institute of Medicine so that women can be better educated about their options, avoid unwanted pregnancies, and have adequate time between each pregnancy to have the best outcomes (Peipert et al., 2012).

Before this amendment was added to the ACA, studies were conducted to measure the uptake and continuation of all birth control methods when provided at no cost to patients. In 2007, the Contraceptive CHOICE Project set out to promote LARC by removing financial barriers and to reduce the numbers of unintended pregnancies by providing free contraception to 10,000 women. When costs were removed, 75% of participants chose LARC methods, which is a stark contrast to the national average of 8.5%. Adolescents chose LARC at approximately the same rate as adults, with younger adolescents (14-17 years old) preferring the implant instead of

the IUD (Eisenberg et al., 2013). This study produced astounding statistics. When this study was examined using a Markov model, it showed that free contraceptive coverage, especially to women who were low-income, prevented more than 286,000 unintended pregnancies. They also predicted that changing healthcare policy based on the results of the Contraceptive Choice Project could prevent as many as 62-78% of abortions every year in the United States (Peipert et al., 2012). Another study in Iowa was conducted that focused on education, advocacy, and removing barriers to access and cost. This study showed a 218% increase in IUD use and 829% increase in implant use. Following this study, the unintended pregnancy rate decreased by 5% and the abortion rate by 19%. From the results of this study, a cost-benefit analysis study was conducted that showed the greatest financial benefit of using LARC was among adolescent mothers (Eisenberg et al., 2013). It is important that providers consider this barrier when recommending this method to patients, but should also realize that changes in the healthcare system are making these methods more accessible. Removing this barrier has shown dramatic increase in LARC use and substantial decrease in unintended pregnancies.

Exposing Myths and Misconceptions

In order for adolescents to choose LARC, the provider must address misconceptions and myths about LARC methods. When each method of birth control was offered and explained to the participants of the CHOICE project, 71% of patients chose LARC—58% chose an IUD while 13% chose the implant (Eisenberg, Secura, Madden, Allsworth, Zhao & Peipert, 2012). Part of this study was also discovering participant's perceptions of the effectiveness of each form of birth control. This study showed that the general trend was "to overestimate the effectiveness of DMPA, the pill, the patch, vaginal rings, condoms and natural family planning methods" (Eisenberg, et al., 2012, p. 479). In adolescents, there may be an even greater disparity between

the perceived effectiveness and the actual effectiveness of these methods due to the common mentality of “personal fable” and invincibility among this group (Hillard, 2012).

Some of the common myths stem from misunderstandings of how the IUD and implant function. Studies have shown that the IUD does not cause abortions, increase risk for Pelvic Inflammatory Disorder (PID), cause infertility, cause ectopic pregnancy or cancer. An IUD prevents the uniting of egg and sperm, so it does not harm an embryo in any way because it prevents it from forming in the first place (Russo et al., 2013). Although there was one IUD developed in the 1970s that increased PID risk, the re-designed method of the IUD does not put a woman at increased risk. Instead, her risk is decreased from the effects of the IUD such as thickened cervical mucus, thinning of the endometrium, and decreased bleeding. Infertility is not a risk with IUD use. When comparing women who have had their IUD removed due to complications and women who have had their IUD removed in order to conceive, the rate of pregnancy is the same. On the other hand, women with diagnosed infertility and women who are pregnant with their first child have reported equivalent percentages of IUD use. Finally, a woman’s risk for ectopic pregnancy while using LARC is significantly lower than it would be for a woman who is not using contraception at all. By preventing the occurrence of pregnancies in general, this method reduces a woman’s risk for ectopic pregnancy. Copper IUDs, such as Paraguard may protect against endometrial and cervical cancer (Russo et al., 2013).

In addition to the myths about LARC, many misconceptions still exist regarding the side effects and the placement procedure. For adolescents who may have preexisting misconceptions about reproductive anatomy, extra explanations may be necessary. It has been suggested that plastic models of the pelvis and uterus with IUD models may be a helpful tool when explaining IUD insertion and function to adolescents (Hillard, 2012). One common myth is that IUDs may

only be placed during a woman's period. Although this may be a convenient time to ensure that there is no existing pregnancy, it is not necessary. Another common concern is that the IUD will not fit in the uterus or that it will get stuck in the uterus. There has been no evidence of size being an issue when placing an IUD, and there is a risk of 0-1.3% of perforation of the uterus during the insertion of an IUD, which is very low (Russo et al., 2013).

It is important to clarify misconceptions of potential side effects of LARC. Nulliparous women report more pain after IUD insertion than multiparous women. The initial pain that they experience, however, should decrease over the weeks following the insertion. Menstrual irregularities are common with LARC, especially methods containing hormones, but the copper IUD (Paraguard) allows for more regular menstrual cycles if this is a concern for the patient. In a study of the side effects of LARC, 21% of patients experienced weight gain when using hormonal methods. Implanon had the highest incidence of weight gain of all forms of LARC. The concentration of hormones in the IUD Mirena is less than the concentration in most oral contraceptives, so it would seem that the risk for weight gain would be lower when using this method. Another side effect is changes in complexion. In another study about the side effects of LARC, 14% of participants reported the appearance of acne after using Implanon with 10% of women experiencing a worsening of symptoms. On the other hand, 59% of women reported an improvement in their acne after using this method. Other concerns include risk of hair loss and osteoporosis. Studies have not shown either of these side effects to be common when using LARC methods (Russo et al., 2013).

Myths and misconceptions are not only present in patient populations but among providers as well. It is important for providers to address doubts they may have about prescribing LARC to patients to ensure that their doubts are not preventing patients from receiving the

highest quality of care. From surveys of clinicians, researchers have found that most clinicians (55%) considered less than a quarter of their patients to be candidates for IUDs (Russo, Miller, & Gold). In this same group, less than half of clinicians considered an IUDs an appropriate method of birth control for nulliparous, immediate postpartum or abortion, or teenage patients. It has also been assumed that women with histories of ectopic pregnancy, PID, and HIV should not use IUDs. These myths are directly contradicting the recommendations of the American Congress of Obstetrics and Gynecology, the Centers for Disease Control and Prevention as well as the World Health Organization. Another survey in “April 2012 of family medicine physicians, obstetrician-gynecologists, and advanced practice clinicians found that 16% continue to consider the IUD unsafe for nulliparous women and 80% rarely or never provide IUDs to this population” (Russo et al., 2013, 18). Another survey of providers in St. Louis found that only 31% of physicians consider the IUD as a contraceptive method for teenagers. In this group, 50% said they would insert one for a 17 year old who already has one child, and only 19% would insert one for a 17 with no children or previous pregnancies (Mestad, 2011). These statistics are discomfoting, considering the IUD is one of the most effective methods of contraception that requires the least compliance. It is crucial that healthcare providers be up to date on the most current information regarding how to best care for their patients. Offering these forms of contraception would significantly decrease the amount of unintended pregnancies every year.

Providers may also have misconceptions about their patients that prevent them from recommending LARC to those who may benefit from it. One belief may be that parental consent is always required for minors to receive IUDs. In 21 states, no parental consent is required. In 25 states, minors may consent for themselves under the condition that they are married, they are a parent, they have been pregnant, or they are putting their health at risk with an unintended

pregnancy. Another provider concern may be that teens will not remember to check the strings on an IUD monthly. It has been suggested that it is more important for teens to know the signs of IUD expulsion rather than checking the strings on a rigid schedule. One of the most common assumptions is that teens prefer condoms and oral contraceptive pills to other forms of contraception. Teens likely request these methods because these are the most familiar to them (Russo et al., 2013). They may be intimidated by the idea of LARC, but without a thorough explanation of how it works and what the procedure entails, the provider should not assume they are opposed to this method. This is especially important considering teen compliance with oral contraceptives and condoms is lower than compliance in adult populations. It is the clinician's responsibility to educate the patient on the most effective methods for preventing pregnancy and to address misconceptions.

Improving Education in Counseling

As these methods are becoming more accessible, it is important for providers to have the training and knowledge about LARC to make this method available to patients at every clinic. Being informed about personal doubts as well as the potential doubts of patients is crucial in providing counseling for patients to help them make the most informed decision.

When providing counseling to a patient who is interested in contraception, it is important to examine the patient's perspective and background knowledge in order to relate to them and to build trust. When considering contraception, many women seek multiple sources of information. A woman's social network is an influential factor in her decision for birth control. Studies have shown that women consult their social network for information about the effectiveness, adverse effects, safety, and use instructions for forms of contraception. It is common for women to place more value on the opinions of friends, mothers, and sisters who have experience with particular

methods than on the recommendations of their provider. On the other hand, women have rejected a particular type of contraception due to misinformation from her social network. The most pervasive myths were related to safety, efficacy, and side effects of particular contraceptive methods. This study also showed differences in social network choices related to race. African American women consulted their family and partners when considering methods of birth control, whereas Latina women consulted friends first (Yee & Simon, 2010).

The best way for providers to understand the patient's perspective is to ask relevant questions. When counseling a patient, it is important to find out how much the patient knows about contraception, where she looks for information, and who influences her contraceptive decisions. This helps the patient open up about the beliefs she may have from her social network. The patient may also be encouraged to bring along a friend, family member, or partner to her appointment to share the decision of a contraceptive method (Yee & Simon, 2010). In adolescents, this is especially important because they may be apprehensive about topics regarding contraception, but they may not want to bring up their fears or concerns with their provider. Adolescents are likely to have questions about their own anatomy that should be addressed to help them better understand how different contraceptive methods work (Hillard, 2012). It is important for providers to also ask their patients about their individual preferences and goals for their contraceptive choice (Dehlendorf et al., 2013).

After the initial introduction of contraceptive methods and the clarification of myths and misconceptions, it is the provider's role to help the patient decide on a method. Women strongly value the effectiveness, safety, and ease of use when they are making contraceptive choices (Eisenberg et al., 2012). Although the theme in contraceptive counseling has been objective sharing of information by the provider with the decision entirely resting with the patient, a

change is occurring. Many patients are saying that they prefer to hear the suggestions of their provider and that they strongly value his or her input. Many patients appreciate the provider personalizing information to the patient's needs and desires, while not pressuring them one way or another. Patients have reported that they want to feel comfortable with their provider, as if he or she were a family member or friend to them. Because birth control discussions may lead to topics that are very personal for the patient, it is the provider's job to have a caring and non-judgmental attitude toward the patient (Dehlendorf et al., 2013).

Although the provider is encouraged to be involved in the patient's decision for birth control, they must not become overinvolved to a point where they are coercing the patient against their wishes to choose a particular method. This may be a sensitive topic for certain minority groups or for people from other countries where contraceptive decisions may not always have the woman's interest as the priority of care. To prevent overstepping the boundaries of the patient, it is important to ask whether the patient would like the provider's input before offering more subjective suggestions. Using manipulative or directive counseling to convince women to use LARC is never acceptable and is extremely problematic for patients. Patients must know that they can trust their providers and that their provider is not trying to fit them into their own agenda. Ultimately, the patient must be the one to make the final decision regarding their contraceptive method even when they involve their provider in the deliberation of different options (Dehlendorf et al., 2013). If there is a way for a woman to hear or read about about someone's personal experience with a particular method of birth control, this can increase the amount of trust a patient has in their provider and may help them with their decision to choose a particular birth control method (Benson, Perrucci, Drey, & Steinauer, 2012).

Discussion of the insertion procedure for LARC is an integral part of counseling,

especially for adolescents who may have reservations about the procedure. Providing concrete details, like the length of the procedure, the size of the device, and how it will feel are important to reduce anxiety in teens. Adolescents may be afraid of the procedure being painful. The pain of the insertion, specifically of the IUD may be reduced by the provider's technique, a soothing environment, and distraction during the procedure by continuing conversation. Warning the patient prior to each part of the procedure is beneficial to the patient as well (Hillard, 2012). For women who are immediately postpartum, the IUD may be inserted more easily since the cervix and uterus have already been manipulated. In a study of 1,317 women over 5 years, who had an IUD inserted within 10 minutes of the delivery of their placenta, only 10% experienced accidental expulsion of the IUD. The advantages for inserting an IUD immediately postpartum are that the woman is not currently pregnant, and she is motivated to obtain contraception. Insertion is convenient because she is already with a healthcare provider, and limited access to care is not an issue (Shukla, Sabuhi & Chandrawati, 2012). This could be a very compelling option for adolescents who are at risk for rapid repeat pregnancy who also may have limited access to healthcare outside the delivery of their child. This option must be discussed during prenatal care or counseling prior to the delivery of the newborn.

When providing counseling, a thorough discussion of the side effects is necessary so that the patient knows what to expect. Some concerns about side effects may be addressed when discussing myths, but providers should make patients aware of all the side effects that may occur with LARC methods. When patients do not understand what the potential side effects are, they may be less likely to begin or continue a method that may be the most effective for them. Evidence has shown that by discussing the side effects, patients are more likely to adhere to their chosen contraceptive method rather than reject it based on fear of the potential side effects.

When a provider does not provide information about the side effects of LARC methods, the patient may think that their experience is abnormal and discontinue the method simply based on lack of information (Dehlendorf et al., 2013). In one study, women chose to have their IUDs removed because of amenorrhea, but it was never made clear to them that this could be an effect of the IUD. It is especially essential that teens understand and anticipate the potential side effects of LARC methods to promote adherence. Since teens commonly believe that they are invincible and that they are an exception to the norm, it is best to overstate the potential for adverse effects. For example, instead of saying that irregular bleeding is a possibility with an IUD, it is best to plan strategies for how to handle irregular bleeding when it happens. Discussing scenarios where teens would have to manage the potential side effects of LARC is an effective method in counseling this group (Hillard, 2012). The most important factor after making a contraceptive choice is the continuation of that method to prevent pregnancy. By giving patients the information they need to anticipate possible side effects or complications, they can know that their experience is not abnormal and that continuing their contraception is safe (Baldwin & Edelman, 2013).

Seeing the Latina Perspective

The most important aspect for care specifically for Latina patients is providing care that addresses the same barriers as care for non-Latinas, while understanding that cultural differences may require extra anticipation and explanations. Many Latina women may be lacking knowledge of contraception and the process of reproduction, which may need to be explained through high quality counseling in the clinical setting (Masinter, Feinglass, & Simon, 2013). Providing culturally competent care for an entire people group is never all-inclusive and must therefore be open to flexibility. Key features of understanding the Latino perspective are recognizing an

emphasis on family, differences in cultural norms, and communication barriers. When working with Latino patients, the goal is not to change their opinions or beliefs on what is the best option for them, but instead to ask questions to better understand their perspective and provide them with the most accurate and current information. It is important not to assume that patients fit into a particular viewpoint, because vast differences exist based on levels of acculturation and experience, which may not be readily apparent during an initial meeting.

Demonstrating cultural sensitivity.

Providing culturally sensitive care is crucial when working with Latina patients. Some of the key contributors to the high birth rate to Latinas include reduced access to contraception, pressure to become pregnant, misunderstandings about side effects from contraception, and their level of acculturation (Quelopana & Alcalde, 2013). It is important that healthcare providers and medical staff recognize these barriers and engage the patient to have an open dialogue. Although the population of Latinas in the United States is increasing, the proportion of physicians and nurses with similar cultural backgrounds is not increasing at the same rate. Members of healthcare teams may find it difficult to be culturally sensitive when they do not share a common background. A study conducted by Russell suggested qualities of culturally sensitive care for Latina adolescents that can be embodied by anyone in a clinic or hospital. First, it is important to have staff with a variety of backgrounds and experiences so that everyone does not necessarily share the same perspective. Asking questions is always valued over making assumptions. Awareness and respect of youth culture as well as Latino culture is important also. Being a role model and communicating shared experiences creates connections as well between the healthcare provider and Latino adolescents (Russell & Lee, 2004). Language barriers are a common issue that can be overcome with a healthcare team that speaks Spanish or having

interpreters in offices and hospitals that serve a large Latino population. When a language barrier exists between the patient and provider, patients have reported feeling rushed at appointments, and they were not as willing to disclose personal information (Dehlendorf et al., 2013).

Difficulties in communication can inhibit the building of trust between patient and provider.

Minority groups, specifically African-Americans and Latinos may have a greater distrust for the health care providers due to experiences with coercive contraception or racism (Dehlendorf et al., 2013). In order to ease that tension, attentiveness and a caring attitude are crucial.

Recognizing distinctive values.

Understanding prominent values in Latino culture can aid providers when discussing contraceptive options with patients. One of the most pervasive and integral values to Latino culture is familialism. The majority of Latinos are very close with their immediate and extended family with intense ties of loyalty to them. In this same vein, it is common for Latino cultures to promote early and high fertility. The importance of family generally outweighs the desire for personal success in education or in a career (Russell & Lee, 2004). This poses an issue when an adolescent becomes pregnant and has not yet completed high school. The assumption for many teens who were raised with an individualistic mindset may be that they have to complete school despite an unforeseen obstacle. For teens who value their families above their own personal interest, raising their child may become their sole focus and completing school may be an afterthought.

In addition to the overarching ideas of familialism, another factor that may affect the teen pregnancy rate is the lack of discussion of sexuality in Latino homes. This is likely a result from the belief that premarital sex is sinful and should simply be avoided through abstinence until marriage (Quelopana & Alcalde, 2013). Whenever adolescents are not educated about how

pregnancy can occur or what they could do to prevent pregnancy, they are at a disadvantage. One study showed that “70% of Latina women have had an unintended pregnancy and over half of pregnancies to Latinas are unintended” (Masinter, et al., 2013, 866). Ninety-two percent of pregnancies to Latina teens were reported as unintentional. This is higher than the national average of 81% of teen pregnancies that are reported as unintentional (Masinter et al., 2013). When discussing contraceptive options with patients, it may be beneficial to include parents or family members to catalyze communication between the patient and their family and to address misconceptions in both groups (Dehlendorf et al., 2013). It is important that the provider avoids assumptions about the religiosity of patients and their contraceptive choices. Although there is a high percentage of Latinas who claim Catholicism as their religion, this may or may not affect their birth control choices. In a study about intended LARC use in patients in two hospitals in North Carolina, researchers found that 41.8% of Latina patients intended to use LARC following their pregnancy. In this study, the percentage of Catholic, Protestant, and patients claiming “other” religious beliefs had almost equal percentages of reported intention to use LARC (Tang, Dominik, Brody, & Stuart, 2013). Latinas are recorded to be generally high users of LARC methods (Park, Rodriguez, Hulett, Darney & Bocanegra, 2012). This receptiveness should be encouraging to providers when initiating counseling. Since many Latinas are noted to be open to LARC methods, raising their awareness of LARC by providing thorough and sensitive counseling may introduce the patient to a desirable and effective method that she did not know she could use.

Understanding acculturation.

The level of acculturation of Latina patients can shape their perspective of contraception and their willingness to use it. Women who have recently immigrated to the U.S. from Central

and South America will likely retain strong attachments to their traditional cultural values (Russell & Lee, 2004). These women generally have lower socioeconomic status and are less likely to have a full time job and access to health insurance. They are also more likely to have strong attachments to Catholicism. Latina women who compose the first generation in their families to immigrate to the U.S. have demonstrated less interest in contraception compared to women who were born in the U.S (Wilson, 2009). In many traditional Latino cultures, women may defer to their partner's desire to have many children without discussing their own desires. A woman's partner may be opposed to contraception, and the cultural expectation may be for women to comply with their partner's wishes (Quelopana & Alcalde, 2013). Whether this expectation is considered consensual or coercive should be determined by having an open dialogue with the patient. Religious beliefs may be influential as well. The assumed relationship between high Catholic religiosity and low contraceptive use is controversial. In one study by Wilson, this relationship was present among adolescents, but not among adults. The study suggests that teens may see the Catholic Church's stance on contraception as more black and white than older women do. There may also be internal conflict in teens who feel that they should follow the rules of the Catholic Church that promote abstinence until marriage. It is possible that sexually active Latina teens do not want to consider contraceptive options because they do not want to acknowledge their divergence from the rules that they value. This can lead to unintended pregnancies among this group (Wilson, 2009).

After spending time in the U.S., however, many women adopt new ideas about their autonomy. Since there is a stronger push in the U.S. for discussions regarding sexuality, contraception, family planning, and Sexually Transmitted Infection (STI) prevention, women become more comfortable sharing their feelings on these topics. As women become more

involved in the culture of the U.S., they may change their perspective on providing for their children. Some of these women have reported that they wanted to limit the number of children they had in order to meet all their needs. Many women believe that contraception is more accessible in the U.S., which makes family planning more feasible for them. This same study found that the level of linguistic acculturation is not a predictor of health care beliefs and practices. Women who may not know English well may still value contraception and want to have control over their reproductive health decisions. Although they may still have ties to their original cultural beliefs, they adapt to the U.S. culture as well creating a “bicultural identity,” (Quelopana & Alcalde, 2013).

Tools for Facilitating Communication

When a woman meets with her healthcare provider, it can be difficult to address all of her questions and concerns since there is a time limit for her appointment. In Dehlendorf et al.’s study, women seeking contraception reported that they felt like verbal instruction from their provider was not sufficient for their learning, since they were being exposed to such a large quantity of new information (2012). These women said that it would be helpful for them to have more information before their meeting with their healthcare provider so they could prepare questions to ask ahead of time. For this reason, the goal of this project is to create a tool to facilitate communication between patients and providers that incorporates the evidence based practices reflected in this paper.

This tool is based on Cox’s framework, the Interaction Model of Client Health Behavior. This theory proposes that when the focus of care is on uniqueness of the patient and the establishment of a solid patient-nurse relationship, the outcomes of patient care can be improved. When interventions are tailored specifically to the individual patient’s needs, they are likely to

have positive health outcomes. Although this theory contains three factors (client uniqueness, patient-provider interaction, and health outcomes), this tool is specifically focused on the patient-provider interaction. This can be further broken down into “affective support, health information, decisional control, and professional/technical competencies,” as is mentioned in the theory (Wagner, Bear & Davidson, 2011, 178). Each of these ideas is reflected in the tool to facilitate these goals.

This is a two-part tool, with one set of instructions for the healthcare provider and another for the patient. The patient’s tool, which is displayed in Appendix A will be administered to all women of childbearing age while they are waiting in the office at the OB-GYN for an appointment. It is likely that this will capture more patients who are already pregnant, which will assess Latina teens at risk for RRP, but it may be given to nulliparous women as well who are considering birth control options. First, the patient will have a brief list of questions to answer while they are waiting. The first questions are intended to provide background information and to get a sense of who the patient is. Then it is important to determine her specific goals for family planning, mainly how many children she has and how many she wants to have. It is important to determine the extent of her social network and who all is involved in her contraceptive decisions (Yee & Simon, 2010). A woman’s social network has significant influence in her contraceptive decisions and should be addressed to give the provider a clear understanding. The woman should be free to say which specific methods of birth control she is requesting and which methods she would like to learn more about. It is important to directly ask whether the woman is open to suggestions from her provider, or if she prefers more objective involvement from him or her. Asking about the patient’s fears and concerns regarding birth control encourages her to be open and allows the provider to address those. The second piece of the patient tool is a list of the

common myths about LARC to give to the patient as she is thinking about her birth control decisions. These may be accompanied by a handout with each form of birth control listed with the effectiveness and a brief description of each. This is commonly found at many OB-GYN offices. Having time before her appointment to go through these questions prepares her to discuss them with her provider during the appointment. This tool was intentionally structured to present information in terms that are clear and simple so that women with different levels of health literacy could benefit from using it. The goal for this tool is to create a genuine, open-ended conversation where the patient feels comfortable sharing her feelings and, in turn, has her needs met.

The second part of the tool, which is displayed in Appendix B is for the providers. The providers have all of the information that is given to the patients with additional points from the research that has been done. First, the provider tool provides instructions for discussing LARC with patients. It is important to introduce each method by providing thorough and objective information to the patient about the effectiveness of each method to help them make an informed decision. The provider should tailor options to the patient based on her needs and desires and dispel any myths that are mentioned or any misconceptions revealed by the patient tool. The provider handout also contains information that may clarify misconceptions the providers may have about LARC use and points that may alleviate fears patients may have. It is also important to clarify that LARC may be an available option for the patient due to the new provisions under the Affordable Care Act. Providing opportunities for patients to hear about other women's experiences with LARC may be helpful for them also when making their decision. The provider should emphasize that it is his or her responsibility to provide the best information to patients in order to deliver the highest standard of care, but the decision ultimately rests with the patient.

Part of the handout for providers provides them with talking points when discussing birth control with Latina women and teens. This sheet is an abbreviated version of the cultural themes mentioned in this paper. It is broken down into showing cultural sensitivity, acknowledging values, and understanding acculturation. When providers may not share the same cultural background as Latina patients, they should give these patients the same quality of care as any other patient without making assumptions, but they should also anticipate addressing issues specific to them. For providers with limited knowledge about aspects of Latina culture that could impact their contraceptive decisions, this tool can be helpful. Although every patient may not agree with the ideas mentioned in the tool, it can be a good starting point in addressing needs in patients who do.

Summary

The goal of this research is to improve the lives of Latina teens with a previous pregnancy, but hopefully it will extend to the greater Latina population and become the standard of practice. Using LARC methods can make a significant impact on the rate of rapid repeat pregnancy and the rate of unintended pregnancies each year. Adequately spacing pregnancies not only gives the mother's body time to recover and become ready for a new pregnancy, but she can also prepare financially, mentally, and socially for the new responsibility she will have by raising another child. When the barriers to LARC are broken down by presenting a patient with the most current and accurate information while providing a non-judgmental and comfortable environment, patients will be more likely to use these methods. By using these methods, women can provide better lives for themselves and their families by ensuring that they are ready and excited to grow their families if and when the time comes.

References

- Baldwin, M. K. & Edelman, A. B. (2013). The effect of Long-Acting Reversible Contraception on rapid repeat pregnancy in adolescents: A Review. *Journal of Adolescent Health*, 52 (2013), S47-S53. <http://dx.doi.org/10.1016/j.jadohealth.2012.10.278>
- Benson, L. S., Perrucci, A., Drey, E. A. & Steinauer, J. E. (2012). Effect of shared contraceptive experiences on IUD use at an urban abortion clinic. *Contraception* 85(2012) 198-203. doi:10.1016/j.contraception.2011.05.021
- Dehlendorf, C., Levy, K., Kelley, A., Grumbach, K. & Steinauer, J. (2013). Women's preferences for contraceptive counseling and decision making. *Contraception* 88 (2013). 250-256. <http://dx.doi.org/10.1016/j.contraception.2012.10.012>
- Eisenberg, D. L., Secura, G. M., Madden, T. E., Allsworth, J. E., Zhao, Q. & Peipert, J.F. (2012). Knowledge of contraceptive effectiveness. *American Journal of Obstetrics and Gynecology* 206 (479), 1-9. <http://dx.doi.org/10.1016/j.ajog.2012.04.012>
- Eisenberg, D., McNicholas, C. & Peipert, J.F. (2013). Cost as a barrier to Long-Acting Reversible Contraceptive (LARC) use in adolescents. *Journal of Adolescent Health* 52(2013), S59-S63. <http://dx.doi.org/10.1016/j.jadohealth.2013.01.012>
- Hillard, P. J. (2013). Practical tips for intrauterine devices use in adolescents. *Journal of Adolescent Health*, 52(2013), S40-S46. <http://dx.doi.org/10.1016/j.jadohealth.2012.09.023>
- Masinter, L. M., Feinglass, J. & Simon, M. A. (2013). Pregnancy intention and use of

- contraception among Hispanic women in the United States: Data from the National Survey of Family Growth, 2006-2010. *Journal of Women's Health* 22(10) 862-870. DOI: 10.1089/jwh.2013.4366
- National Latina Institute for Reproductive Health (2012). Just the Facts: Latinas & Contraception. Retrieved from <http://www.nclr.org/images/uploads/publications/NLIRH-Fact-Sheet-Latinas-and-Contraception-020912.pdf>
- Park, H., Rodriguez, M. I., Hulett, D., Darney, P. D. & Bocanegra, H. T. (2012). Long-acting reversible contraception method use among Title X providers and non-Title X providers in California. *Contraception* 86(2012) 557-561.
<http://dx.doi.org/10.1016/j.contraception.2012.04.006>
- Peipert, J. F., Madden, T., Allsworth, J. E. & Secura, G. M. (2012). Preventing unintended pregnancies by providing no-cost contraception. *Obstetrics & Gynecology* 120(6) 1291-1297. DOI: <http://10.1097/AOG.0b013e318273eb56>
- Quelopana, A. M. & Alcalde, C. (2013). Exploring knowledge, belief and experiences in sexual and reproductive health in immigrant Hispanic women. *Journal of Immigrant and Minority Health* DOI 10.1007/s10903-013-9807-7
- Russell, S. T., Lee, F.C & The Latina/o Teen Pregnancy Prevention Workgroup. (2004). Practitioner's perspectives on effective practices for Hispanic teenage pregnancy prevention. *Perspectives on Sexual and Reproductive Health* 36(4) 142-149.
<http://www.jstor.org/stable/1520238>
- Russo, J., Miller, E. & Gold, M. A. (2013). Myths and misconceptions about Long-Acting Reversible Contraception (LARC). *Journal of Adolescent Health* 52(2013) S14-S21.

<http://dx.doi.org/10.1016/j.jadohealth.2013.02.003>

Shukla, M., Sabuhi, Q. & Chandrawati (2012). Post-placental intrauterine device insertion—a five year experience at a tertiary care centre in north India. *Indian Journal of Medical Research* 136(3) 432-435. <http://www.ijmr.org.in/article.asp?>

Tang, J. H., Dominik, R., Re, S., Brody, S. & Stuart, G. S. (2013). Characteristics associated with interest in Long-Acting Reversible Contraception in a postpartum population. *Contraception* 88 (2013) 52-57. <http://dx.doi.org/10.1016/j.contraception.2012.10.014>

The National Campaign to Prevent Teen and Unplanned Pregnancy (2013). Fast Facts: Teen Pregnancy and Childbearing Among Latina Teens. Retrieved from http://www.thenationalcampaign.org/resources/pdf/FastFacts_TPChildbearing_Latinos.pdf

Wagner, D.L., Bear, M., & Davidson, N.S. (2011) Measuring patient satisfaction with postpartum teaching methods used by nurses within the Interaction Model of Client Health Behavior. *Research and Theory for Nursing Practice: An International Journal* 25(3) 176-190. <http://dx.doi.org/10.1891/1541-6577.25.3.176>

Wilson, E. K. (2009). Differences in contraceptive use across generations of migration among women of Mexican origin. *Maternal Child Health Journal* (2009)13, 641-651. Doi: 10.1007/s10995-008-0382-9

Yee, L. & Simon, M. (2010). The role of social network in contraceptive decision-making among young, African American and Latina women. *Journal of Adolescent Health* 47(2010) 374-380. doi:10.1016/j.jadohealth.2010.03.014

Appendix A

Patient Handout

Please answer the following questions:

Tell us about yourself, where are you from originally? What are some goals you have?

How many children do you have? _____

How many children do you wish to have? _____

Are you currently in a serious relationship? _____ With a male partner? ____ Female partner? ____

Who is involved in your decisions for birth control?

Who do you go to for advice when considering methods for birth control?

Are you interested in a particular method of birth control, and if so, which one?

Which of the following methods of birth control are you familiar with?

Spermicide (foams or creams) _____

Fertility awareness (Rhythm) method _____ Shots _____

Diaphragm _____ Vaginal ring _____

Male condom _____ Patch _____

Female condom _____ Female sterilization _____

Withdrawal (Pulling-out) _____ IUD (Mirena, Paraguard, Skyla) _____

Cervical cap _____ Implant (Implanon, Nexplanon) _____

Sponge _____ Birth control pills _____

Which of the methods above would you like more information about?

Are you open to suggestions from your provider about birth control methods? _____

What concerns and fears do you have about birth control?

What is most important to you in deciding which method of birth control you use?

What questions do you have for your provider regarding birth control?

The Truth about the Myths:

- IUDs DO NOT cause abortions.
 - IUDs prevent fertilization. The egg and sperm do not come together.
 - Copper in the Paraguard IUD prevents the egg and sperm from joining together.
 - The Mirena IUD increases mucus at the opening of the womb and makes the environment of the womb unfavorable for a pregnancy to occur.
- IUDs DO NOT cause an infection in the uterus (but sexually transmitted infections do!).
 - Current IUDs are very safe with low infection rates.
 - Risk is higher in the first 20 days after insertion, but if a patient is screened and treated for gonorrhea and chlamydia, an infection is very unlikely to develop.
 - The Mirena helps prevent infection by thickening mucus at the mouth of the womb and making the environment of the womb unfavorable for an infection to develop.
- IUDs DO NOT cause infertility (sexually transmitted infections might).
 - The pregnancy rates are the same for women who have their IUD removed because of problems and those who have it removed to become pregnant.
- IUDs DO NOT cause a tubal pregnancy.
 - IUDs lower the risk of tubal pregnancy by preventing unplanned pregnancies.
- IUDs DO NOT cause cancer.
 - IUDs may actually decrease your risk of cancer of the lining of the womb.
 - IUDs containing copper may protect against cervical cancer.

Clarifying Common Misconceptions:

- Long Acting Reversible Contraceptives (LARC) MAY cause menstrual irregularities.
 - Hormonal methods
 - Paragard may cause an increase in bleeding
 - Mirena may cause a decrease in bleeding
 - Implants may cause irregular or infrequent bleeding
 - Regular menstrual cycles are more likely with a copper IUD (Paraguard) versus the hormone IUD (Mirena).
- IUDs MAY cause minor discomfort with insertion.
 - Women may experience minor discomfort (cramping) in the first 30 minutes after insertion.
 - Taking an over-the-counter pain medication prior to insertion may reduce discomfort.
- Long Acting Reversible Contraception (LARC) MAY cause weight gain.
 - Weight gain is a potential side effect from LARC hormonal methods.
 - The levels of hormones in Mirena IUDs are lower than birth control pills and implants, which could mean reduced risk for weight gain.
- Long Acting Reversible Contraception (LARC) MAY improve acne.
 - The majority of patients actually have improvement in acne when using LARC, but there is a small group of people whose acne becomes worse with LARC.
- The IUD does NOT have to be placed during a woman's period.
 - This may be the ideal time to guarantee that you are not pregnant, but it is not

required.

- The IUD is NOT difficult to insert and remove.
 - IUDs can be inserted and removed at your provider's office.
 - The procedure is simple and takes 5-10 minutes.
- **IUDs can be used whether a person has been pregnant before or not.**

Appendix B

Patient Handout (Spanish)

Por favor conteste las siguientes preguntas:

Cuéntenos un poco sobre usted, ¿de dónde es originalmente? ¿Qué metas tiene Ud.?

¿Cuántos hijos tiene? _____

¿Cuántos hijos desea tener? _____

¿Está usted actualmente en una relación seria? _____ Con hombre? _____ Con mujer? _____

¿Quien esta involucrado en sus decisiones sobre la anticoncepción?

¿A quien consulta para consejos en métodos de anticoncepción?

¿Hay un tipo de anticoncepción en especial que le interesa?

¿Cuales métodos de anticoncepción está usted familiarizado?

Espermicida _____

Métodos para identificar
el periodo fértil _____

Diafragma _____

Condón masculino _____

Condón femenino _____

Coitus interruptus _____

Capuchón cervical _____

Implante (Implanon, Nexplanon) _____

Inyección _____

Anillo vaginal _____

Parche _____

Esterilización femenina _____

DIU--Dispositivo intrauterino

Mirena, Paraguard, Skyla) _____

Píldora _____

Esponja _____

¿Le gustaría obtener más información sobre cualquiera de estos métodos? ¿Cuales?

¿Esta dispuesta a escuchar sugerencias de su doctor sobre las opciones de anticoncepción?_____

¿Qué preocupaciones y temores tiene Ud. acerca de la anticoncepción?

¿Qué es más importante para Ud. en cuanto a su decisión de utilizar un método de anticoncepción?

¿Qué preguntas tiene Ud. para el doctor acerca de anticonceptivos?

La verdad sobre los mitos:

- Los DIU NO causan abortos.
 - Los DIU previenen la reproducción. El óvulo y el espermatozoide no se juntan.
 - Cobre en el Paraguard DIU impide que el óvulo y el espermatozoide se unan entre sí.
 - El DIU Mirena aumenta la mucosidad en la apertura del útero y hace que el ambiente del útero sea desfavorable para que se produzca un embarazo.
- Los DIU NO causan una infección en el útero (sin embargo, ¡las infecciones de transmisión sexual sí lo hacen!).
 - Los DIU actuales son muy seguros con bajas tasas de infección.
 - El riesgo es mayor en los primeros 20 días después de la introducción, pero si un paciente es evaluado y recibe tratamiento para la gonorrea y la clamidia, no es muy probable que desarrolle una infección.
 - El Mirena ayuda a prevenir la infección al espesar el moco en la boca de la matriz y haciendo el ambiente del útero desfavorable para una infección en desarrollarse.
- Los DIU NO causan infertilidad (infecciones de transmisión sexual sí podrán).
 - Las tasas de embarazo son las mismas para las mujeres que tienen su DIU eliminado debido a problemas y los que lo tienen eliminado porque quieren quedar embarazadas.
- Los DIU NO causan un embarazo tubárico.
 - DIU reducen el riesgo de embarazo ectópico, ya que previenen embarazos no planificados.
- Los DIU NO causan cáncer.
 - Los DIU en actualidad pueden reducir el riesgo de cáncer del revestimiento del útero.
 - Los DIU que contienen cobre pueden proteger contra el cáncer de cuello uterino.

Aclarando los conceptos erróneos más comunes:

- Anticonceptivos Prolongados y Reversible (LARC) PUEDEN causar irregularidades menstruales.
 - Los métodos hormonales
 - Paragard puede causar un aumento en el sangrado
 - Mirena puede causar una disminución en el sangrado
 - Los implantes pueden causar sangrado irregular o menos frecuente
 - Ciclos menstruales regulares son más probables con un DIU de cobre (Paragard) en comparación con el DIU hormonal (Mirena).
- Los DIU PUEDEN causar molestias de menor importancia con la inserción.
 - Las mujeres pueden experimentar molestias leves (cólicos) en los primeros 30 minutos después de la inserción.
 - Tomando un medicamento de venta libre, para el dolor antes de la inserción puede reducir el malestar.
- Anticonceptivos Prolongados y Reversible (LARC) PUEDEN causar aumento de peso
 - El aumento de peso es un efecto secundario que puede suceder con los métodos hormonales LARC.

- Los niveles de hormonas en Mirena son más bajas que las píldoras anticonceptivas y los implantes que podría significar un menor riesgo de aumento de peso.
- Anticonceptivos Prolongados y Reversible (LARC) ayuda a disminuir el acné
 - La mayoría de los pacientes realmente tienen una mejoría en el acné cuando se usa LARC, pero hay un pequeño grupo de personas cuyo acné empeora con LARC .
- Los DIU NO tienen que ser colocados durante su periodo
 - Este puede ser el momento ideal para garantizar que usted no está embarazada, pero no es necesario.
- El DIU NO es difícil de poner y quitar.
 - Los DIU pueden ser insertados y retirados en el consultorio.
 - El procedimiento es simple y toma 5-10 minuto.
- **Los DIU se pueden utilizar si una persona ha estado embarazada o no.**

Appendix C

Provider Handout

Introduction to Birth Control (initial worksheet for patient while waiting)

- Tell us about yourself, where are you from originally? What are some goals you have?
- How many children do you have?
- How many children do you wish to have?
- Are you currently in a relationship? With a male partner? Female partner?
- Who is involved in your decisions for birth control?
- Who do you go to for advice when considering methods for birth control?
- Are you interested in a particular method of birth control and if so, which one?
- Which of the following methods of birth control are you familiar with (check the boxes)?
(Spermicide, Fertility awareness method, Diaphragm, Male condom, Female condom, Withdrawal, Cervical cap, Sponge, Shots, Vaginal ring, Patch, Female sterilization, IUD [Mirena, Paraguard, Skyla], Implant [Implanon, Nexplanon], Birth control pills)
- Which of the methods above would you like more information about?
- Are you open to suggestions from your provider about birth control methods?
- What concerns and fears do you have about birth control?
- What is most important to you in deciding which method of birth control you use?
- What questions do you have for your provider regarding birth control?

The Truth about the Myths¹

- IUDs DO NOT cause abortions.
 - IUDs prevent fertilization. The egg and sperm do not come together.
 - Copper in the Paraguard IUD prevents the egg and sperm from joining together.
 - The Mirena IUD increases mucus at the opening of the womb and makes the environment of the womb unfavorable for a pregnancy to occur.
- IUDs DO NOT cause an infection in the uterus (but sexually transmitted infections do!).
 - Current IUDs are very safe with low infection rates.
 - Risk is higher in the first 20 days after insertion, but if a patient is screened and treated for gonorrhea and chlamydia, an infection is very unlikely to develop.
 - The Mirena helps prevent infection by thickening mucus at the mouth of the womb and making the environment of the womb unfavorable for an infection to develop.
- IUDs DO NOT cause infertility (sexually transmitted infections might).
 - The pregnancy rates are the same for women who have their IUD removed because of problems and those who have it removed to become pregnant.
- IUDs DO NOT cause a tubal pregnancy.
 - IUDs lower the risk of tubal pregnancy by preventing unplanned pregnancies.
- IUDs DO NOT cause cancer
 - IUDs may actually decrease your risk of cancer of the lining of the womb

¹ Russo, Miller, & Gold, 2013

- IUDs containing copper may protect against cervical cancer.

Clarifying Common Misconceptions²

- Long Acting Reversible Contraceptives (LARC) MAY cause menstrual irregularities.
 - Hormonal methods
 - Paragard may cause an increase in bleeding
 - Mirena may cause a decrease in bleeding
 - Implants may cause irregular or infrequent bleeding
 - Regular menstrual cycles are more likely with a copper IUD (Paragard) versus the hormone IUD (Mirena).
- IUDs MAY cause minor discomfort with insertion.
 - Women may experience minor discomfort (cramping) in the first 30 minutes after insertion.
 - Taking an over-the-counter pain medication prior to insertion may reduce discomfort.
- Long Acting Reversible Contraception (LARC) MAY cause weight gain.
 - Weight gain is a potential side effect from LARC hormonal methods.
 - The levels of hormones in Mirena are lower than birth control pills and implants, which could mean reduced risk for weight gain.
- Long Acting Reversible Contraception (LARC) MAY improve acne.
 - The majority of patients actually have improvement in acne when using LARC, but there is a small group of people whose acne becomes worse with LARC.
- The IUD does NOT have to be placed during a woman's period.
 - This may be the ideal time to guarantee that you are not pregnant, but it is not required.
- The IUD is NOT difficult to insert and remove.
 - IUDs can be inserted and removed at your provider's office.
 - The procedure only takes 5-10 minutes.
- **IUDs can be used whether a person has been pregnant before or not.**

² Russo et al., 2013

Instructions for provider to introduce LARC

- Introduce methods from most effective to least effective, giving equal time to each method, and explain each objectively.
- Based on the patient's medical history, rule out methods that are not feasible for her.
- If the patient reports aversion from a form of contraception that could be the most effective for her, ask what is concerning about it.
- Dispel any myths (common myths are already given to the patient with her handout).
- For patients who are open to LARC methods, explain the following:
 - **It is the most effective** method of birth control besides sterilization and requires the least compliance.
 - LARC is safe for nulliparous and multiparous teens and adults and has been recommended by the American Congress of Obstetricians and Gynecologists as a “top-tier” method of contraception.
 - LARC is covered under most insurance plans after the passing of the Affordable Care Act.
 - Explain both the IUD and implant options and show patients the devices if possible.
 - Explain fertility rates following removal of devices.
 - Ask patient if they know anyone who has used a LARC method and what they have heard about it.
 - Remind the patient that this is her decision. As her provider, your role is to explain to her the most effective options, but she has the freedom to decide which method is best for her.

Why promote LARC?

- LARC methods are extremely underused in patients despite having the highest effectiveness of all methods. Only 40-55% of clinicians discuss these methods with patients.
- In studies where cost was removed and patients were educated about all methods of contraception, 75% of patients chose LARC methods.³
- LARC is effective at preventing over 99% of pregnancies with continuation rates of 80-90%. Methods such as the pill, patch, vaginal rings, and injections are about 90% effective at preventing pregnancy with a continuation rate of about 40-50%. In teens, the effectiveness of these methods is usually lower than 90% because of inconsistent use.⁴
- Nulliparous, postpartum, and post-abortion patients are candidates for LARC.
- Women with histories of ectopic pregnancy, PID, or HIV are still candidates for LARC by recommendation of the CDC and WHO.⁵
- The American Congress of Obstetricians and Gynecologists (ACOG) recommends that intrauterine devices (IUDs) and implants “should be considered as first-line choices for

³ Eisenberg, McNicholas, & Peipert, 2013

⁴ Baldwin & Edelman, 2013

⁵ Russo et al., 2013

both nulliparous and parous adolescents.”⁶

- Patients have many misconceptions about these methods from friends, family, and social media, which should be addressed during contraceptive counseling.
- Addressing misconceptions about patients receiving LARC⁷
 - Parental consent is not required in 21 states for IUD insertions. Twenty-five states allow minors to consent if they are married, are a parent, have been previously pregnant, or are at risk for health complications from an unintended pregnancy.
 - Checking strings of IUDs monthly is not required. It may be more beneficial to educate patients about the signs of IUD expulsion instead.
 - Teens do not always prefer condoms and oral contraceptives.
 - Teens may choose these methods because they have more knowledge about them with easier access, and they may be less educated about other methods.
- Explain the side effects once the patient has decided on a method.⁸
 - When discussing these methods with teens, it is better to over-state the side effects than to under-state them due to their developmental characteristic of “personal fable,” or thinking they are invincible.
 - Help the teen think through scenarios where the adverse effect occurs, help them develop plans to handle this side effect, and give them a phone number to call to discuss issues as they may occur.
- The Affordable Care Act requires all FDA-approved contraceptives be covered by insurance with no cost-sharing to patients. This makes LARC a more feasible method of contraception for more patients.⁹
- Using contraceptives to plan and space pregnancies improves the health of a woman and her current and future children. Ensuring that women access to effective contraception reduces the risk of maternal death, low birth weight, and infant mortality.¹⁰

Latino perspective for providers

- Latina teens currently have the highest birth rate among all teens—more than one and a half times higher than the overall teen birth rate.¹¹
- In 2008, the Latina birth rate was highest in the southeastern United States.¹²
- Latinas have been noted to be high users of LARC.¹³

Cultural Sensitivity

- This high birth rate among Latina women has been associated with lack of contraception use due to problems with accessibility, pregnancy coercion, concern

⁶ Hillard, 2012

⁷ Russo et al., 2013

⁸ Hillard, 2012

⁹ Eisenberg et al., 2013

¹⁰ National Latina Institute for Reproductive Health, 2013

¹¹ The National Campaign to Prevent Teen and Unplanned Pregnancy, 2013

¹² The National Campaign to Prevent Teen and Unplanned Pregnancy, 2013

¹³ Park, Rodriguez, Hulett, Darney & Bocanegra, 2012

- about contraception side effects, and the impact of acculturation.¹⁴
- Staff members' skills, experiences, and commitment to helping adolescents are more important than their language ability or cultural heritage.¹⁵
- Culturally sensitive staff understand youth culture and language, share personal experiences, are role models and have an awareness of Latino cultures and acculturation.¹⁶
- It is important to consider that Latinos and other minority groups may not trust the health care system, due to past experience with coercive family planning programs fostering racism.

Values¹⁷

- Sexuality is a topic many Latino families avoid discussing, and the discussions about sexuality that do occur within families may not be extensive.
- The Latino culture focuses on family, which encourages early and high fertility. Being a mother is one of the most revered roles in Latino culture, so there is less emphasis on continuing education once an adolescent becomes pregnant.
- The value of family and motherhood may be stronger than predominant U.S. values of individual success through educational and occupational achievements.
- Due to the importance of family in Latino cultures, many practitioners view the involvement of parents and extended family members in contraceptive decisions as very important, as long as they are not threatening to the patient.

Acculturation

- Traditional Hispanic values are strongest among those women who are least acculturated in the United States.¹⁸
- Some women's decisions regarding birth control are made by their husband, and they are expected to comply without complaint whether they agree or not.
- Among nulliparous women in their teens and twenties both first generation immigrant women and women who were born outside the U.S. but have lived the majority of their lives in the U.S. were found to be significantly less likely to use a contraceptive method than women born in the U.S.¹⁹
- Women's reservations about contraception may be because they simply want to start having children as soon as possible, or that they are afraid that they may end up being infertile if they use contraception prior to having a child.²⁰
- A previous study of Latina women found no association between religiosity and contraceptive use, but that study did not focus on teens.²¹

¹⁴ Quelopana & Alcalde, 2013

¹⁵ Russell & Lee, 2004

¹⁶ Russell & Lee, 2004

¹⁷ Russell & Lee, 2004

¹⁸ Russell & Lee, 2004

¹⁹ Wilson, 2009

²⁰ Wilson, 2009

²¹ Wilson, 2009

- Teens have been less likely to use contraception for religious reasons. This could be because they are more strongly influenced by the Church's prohibition of contraception than older women.²²
- Teens may see the Catholic Church's stance on contraception as more black and white than older women do. There may also be internal conflict in teens who feel that they should follow the rules of the Catholic Church that promote abstinence until marriage. It is possible that sexually active Latina teens do not want to consider contraceptive options because they do not want to acknowledge their divergence from the rules that they value. This can lead to unintended pregnancies among this group.²³
- Women have said that they learned more about contraception and were encouraged to use it when they had contact with a health care provider after immigrating to the U.S.²⁴
- Women believed that since coming to the U.S. they developed autonomy over their own body. Many women think that that contraception is more available in the U.S.²⁵
- A woman's level of linguistic acculturation is not a predictor of health care beliefs and practices. Women who may not know English well may still value contraception and want to have control over their reproductive health decisions.²⁶

²² Wilson, 2009

²³ Wilson, 2009

²⁴ Quelopana & Alcalde, 2013

²⁵ Quelopana & Alcalde, 2013

²⁶ Quelopana & Alcalde, 2013

References:

- Eisenberg, D., McNicholas, C. & Peipert, J.F. (2013). Cost as a barrier to Long-Acting Reversible Contraceptive (LARC) use in adolescents. *Journal of Adolescent Health* 52(2013), S59-S63. <http://dx.doi.org/10.1016/j.jadohealth.2013.01.012>
- Baldwin, M. K. & Edelman, A. B. (2013). The effect of Long-Acting Reversible Contraception on rapid repeat pregnancy in adolescents: A Review. *Journal of Adolescent Health*, 52 (2013), S47-S53. <http://dx.doi.org/10.1016/j.jadohealth.2012.10.278>
- Russo, J., Miller, E. & Gold, M. A. (2013). Myths and misconceptions about Long-Acting Reversible Contraception (LARC). *Journal of Adolescent Health* 52(2013) S14-S21. <http://dx.doi.org/10.1016/j.jadohealth.2013.02.003>
- Hillard, P. J. (2013). Practical tips for intrauterine devices use in adolescents. *Journal of Adolescent Health*, 52(2013), S40-S46. <http://dx.doi.org/10.1016/j.jadohealth.2012.09.023>
- National Latina Institute for Reproductive Health (2012). Just the Facts: Latinas & Contraception. Retrieved from <http://www.nclr.org/images/uploads/publications/NLIRH-Fact-Sheet-Latinas-and-Contraception-020912.pdf>
- The National Campaign to Prevent Teen and Unplanned Pregnancy (2013). Fast Facts: Teen Pregnancy and Childbearing Among Latina Teens. Retrieved from http://www.thenationalcampaign.org/resources/pdf/FastFacts_TPChildbearing_Latinos.pdf
- Park, H., Rodriguez, M. I., Hulett, D., Darney, P. D. & Bocanegra, H. T. (2012). Long-acting reversible contraception method use among Title X providers and non-Title X providers in California. *Contraception* 86(2012) 557-561. <http://dx.doi.org/10.1016/j.contraception.2012.04.006>
- Quelopana, A. M. & Alcalde, C. (2013). Exploring knowledge, belief and experiences in sexual and reproductive health in immigrant Hispanic women. *Journal of Immigrant and Minority Health* DOI 10.1007/s10903-013-9807-7
- Russell, S. T., Lee, F.C & The Latina/o Teen Pregnancy Prevention Workgroup. (2004). Practitioner's perspectives on effective practices for Hispanic teenage pregnancy prevention. *Perspectives on Sexual and Reproductive Health* 36(4) 142-149. <http://www.jstor.org/stable/1520238>
- Dehlendorf, C., Levy, K., Kelley, A., Grumbach, K. & Steinauer, J. (2013). Women's Preferences for Contraceptive Counseling and Decision Making. *Contraception* 88 (2013). 250-256. <http://dx.doi.org/10.1016/j.contraception.2012.10.012>

Wilson, E. K. (2009). Differences in contraceptive use across generations of migration among women of Mexican origin. *Maternal Child Health Journal* (2009)13, 641-651. Doi: 10.1007/s10995-008-0382-9